STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 105
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

PROFESSIONAL SUPORT SERVICES
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. Prior to submitting a licensure application and fee to Health Care Facilities ensure that a tentative provider agreement letter is obtained from the Department of Mental Retardation Services (DMRS). Submit a notarized application along with the appropriate licensure fee and a copy of the letter from DMRS to the address at the top of the application.

2. Approximately thirty (30) to forty-five (45) days prior to your being ready to open your facility you will need to send a letter to the Regional Office in your area to request a survey of the facility. The Regional Office will notify you to schedule the survey. Be certain that you have given yourself plenty of time to have your policies and procedures in order. If you are not ready on the date of survey it will most likely be thirty (30) days or more before the survey can be rescheduled.

3. Once the survey has been completed the surveyor will tell you if your facility is going to be approved for licensure. The surveyor will forward the appropriate forms to the Regional Office for processing. When the Regional Office completes their tasks the appropriate forms are forwarded to the Central Office Licensure Division in Nashville for processing. The license will then be ordered and an approval letter will be sent to the facility which provides the license number and date of the approval. Once the facility receives the approval letter you may begin providing services. If you would like to have the letter faxed to you so that you may begin operating immediately you may call the Central Office to request this. The license should be received in your facility within seven (7) to ten (10) days.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 105
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent to the address at the top of the application. Include the name of the facility and the projected date of the change of ownership.

2. A letter will be sent acknowledging the receipt of the application and fee. Once the change of ownership has occurred and you receive the closing documents you will need to send a copy of the bill of sale or the documents that indicate that you are now the owner of the facility to:

   Health Care Facilities
   227 French Landing, Suite 105
   Heritage Place Metrocenter
   Nashville, Tennessee 37243

3. When the bill of sale or closing documents are received, this office will notify the Regional Office in your area to request an approval of the change of ownership to be effective the date the closing documents were signed. The Regional Office will review the facility file to see if a survey has been conducted within the previous twelve (12) months with no major deficiencies. If so, an approval form will be submitted to the central office in Nashville to process the change of ownership. If a survey has not been conducted within the previous twelve (12) months or if there were major deficiencies which have not been corrected an on-site survey of the facility will be conducted before the change of ownership is approved.

4. The central office in Nashville will then order a new license for the facility and send a letter to the facility to indicate the change of ownership has been processed. The new license should be received by your facility within seven (7) to ten (10) days. The new ownership can continue to operate the facility under the previous owners license until the new license is received in the facility.

State of Tennessee
Department of Health
227 French Landing, Suite 105
Heritage Place Metrocenter
Nashville, Tennessee 37247-0508
(615) 741-7221

PROFESSIONAL SUPPORT SERVICES
APPLICATION FOR LICENSE

Name of the Facility/Agency _____
Location of the Facility
Street _____ City _____
County _____ State _____ Zip _____
Telephone Number _____ Fax Number _____ E-Mail address _____
Twenty-four (24) hour emergency phone number _____
Administrator _____

Have you (administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)? Yes _____ No _____

If yes, what charge(s)? _____

Where convicted and date: _____

Mailing address of facility if different from the location address
Street _____
City _____ State _____ Zip _____

Ownership of Building _____ _____
Name Phone
Mailing Address _____

FEE SCHEDULE: $200 (Applies to currently licensed Home Health Agency and/or independent Therapists contracted with Mental Health to provide ST, PT, and OT)
$800 (If contracted with Mental Health to provide SN only and you are not a currently licensed Home Health Agency)

1. Geographic area served by Agency: (list county or counties) If additional space is needed please use a separate page.

_____

_____

_____

Department Use Only: License No. _____ Fee _____

Date License Granted _____

3. Check type of services provided:

a. Skilled Nursing _____ Occupational Therapy _____
b. Physical Therapy _____ Speech Therapy _____

OWNERSHIP OF BUSINESS

1. a. Check the type of Legal Entity:

____ Individual ____Partnership _____ Corporation _____ Limited Liability Company

____ Church Related _____ Government/County _____ Other

b. Check one: _____ For Profit _____ Non-profit

c. Legal Entity Checked in 1.a:

Name _____ Phone _____

Address _____

e. List name(s) and address(es) of individual owner, partners, directors of the corporation, or head of the governmental entity:

Name	Address	City, State, Zip
Name	Address	City, State, Zip
Name	Address	City, State, Zip

If additional space is needed please us a separate sheet

2. Is your facility/organization accredited by any other accrediting body (i.e., JCAHO, CARF, etc)?
Yes _____ No _____ Expiration Date _____

3. a. Is this facility chain affiliated? Yes _____ No _____

b. If yes, list name, address and phone number of the parent company.

Name _____ Phone _____

Address _____

4. a. If a corporation, is there a holding company/parent corporation? Yes _____ No _____

b. If yes, list the name, address and phone number of the hold company/parent corporation.

Name _____ Phone _____

Address _____

5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?
Yes _____ No _____

b. If yes, list names and addresses of all such facilities

_____

_____

6. a. Do you have a contract with a management firm to operate this facility? Yes _____ No _____

If yes, specify dates: From _____ To _____

_____

b. If yes, please specify name of firm: _____ Phone _____

Address: _____

7. a. Have any owners of the disclosing entity ever been denied a license or had a license suspended or revoked for a health care facility in Tennessee or in any other state? Yes _____ No _____

If yes, where? _____ When? _____

For what reason? _____

VERIFICATION BY NOTARY PUBLIC

Signer for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee code annotated, § 68-11-201.

Signer also certifies that a policy has been implemented to inform all employees of their obligation under § 71-6-103 to report incidents of abuse or neglect.

_____ _____ _____

(Signed) The Applicant Title or Position Date

State of Tennessee

County of _____

The above named applicant (print name) _____, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to before this _____ , day of _____

Month Year

Notary Public: _____

My commission expires: _____

G4012324